STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 BUILDING 155215 10/19/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3700 CLARKS CREEK RD PLAINFIELD HEALTH CARE CENTER PLAINFIELD, IN46168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE K0000 Preparation and/or execution K0000 A Life Safety Code Recertification and of this Plan of Correction in State Licensure Survey was conducted by general, or any corrective the Indiana State Department of Health in action does not constitute an accordance with 42 CFR 483.70(a). admission or agreement by **Plainfield Health Care Center of** Survey Date: 10/19/11 the facts alleged or the conclusions set forth in the statement of deficiencies. The Facility Number: 000121 Plan of Correction and specific Provider Number: 155215 corrective actions are prepared AIM Number: 100290940 and/or executed solely because of provisions of federal and/or state laws. Surveyor: Mark Caraher, Life Safety Code Specialist **Plainfield Health Care Center** desires this Plan of Correction At this Life Safety Code survey, Plainfield to be considered the facility's Health Care Center was found not in Allegation of Compliance. Compliance is effective on compliance with Requirements for November7th, 2011 Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. The facility has a capacity of 189 and had a census of 135 at the time of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HHL021

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	IDENTIFICATION NUMBER:  A. BUILDING  COM		(X3) DATE ( COMPL 10/19/20	ETED	
	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE ARKS CREEK RD IELD, IN46168		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K0021 SS=E	The facility was with the aforeme requirements as a following:  Any door in an exienclosure, horizon	t passageway, stairway tal exit, smoke barrier or					
	by devices arrange such doors by zon upon activation of: a) the required ma b) local smoke det smoke passing thr required smoke de	nual fire alarm system; ectors designed to detect ough the opening or a etection system; and orinkler system, if installed.					
	facility failed to a serving hazardou kitchen was held arranged to autor or close the door fire alarm system could affect any	ation and interview, the ensure 1 of 11 doors is areas such as the open only by a device matically close the door upon activation of the in. This deficient practice resident, staff or visitor in the west kitchen door into doom.	K	0021	K 021:It is the policy of this facility to ensure doors serve hazardous areas such as the kitchen are held open only ledvice arranged to automatically close the doo upon activation of the fire alarm system. All residents have the potential to be affected by this finding. Maintenance Director installed a magnetic door state.	ving e be a r	11/07/2011

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE S COMPL	
		155215	A. BUII B. WIN	LDING IG		10/19/2	011
N. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	DROLUBER OF SUPER-	<u> </u>	J. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIER			3700 CL	ARKS CREEK RD		
PLAINFI	ELD HEALTH CARE	ECENTER		PLAINF	ELD, IN46168		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL  I SC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	Findings include  Based on observe Maintenance Tect the facility from 10/19/11, the we main dining room door stop on the allow the door to upon activation of Based on intervior observation, the Technician states propped open will meals in the main concluded but ackitchen door was door stop on the	ation with the Assistant chnician during a tour of 1:00 p.m. to 3:45 p.m. on st kitchen door into the m was held open by a floor which would not o close automatically of the fire alarm system. ew at the time of Assistant Maintenance d the west kitchen door is the a door stop only after m dining room have cknowledged the west spropped open with a floor and the door would ctivation of the fire alarm		TAG	that is wired to the fire alar panel to the west kitchen door. As part of the preventative maintenance program, Maintenance Dire will continue to monitor do for proper release upon activation of the fire alarm system. Dietary staff has be in-serviced on not propping doors open in the kitchen. staff found to be non-comp with the points of the in-ser will be further educated by Dietary Supervisor and/or progressively disciplined a appropriate.	ctor ors en 3 Any liant rvice the	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155215				LDING	NSTRUCTION  01	(X3) DATE COMPL 10/19/2	ETED
	PROVIDER OR SUPPLIER			3700 CL	DDRESS, CITY, STATE, ZIP CODE LARKS CREEK RD IELD, IN46168		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0025 SS=E	least a one half ho accordance with 8 terminate at an atr protected by fire-ra glass panels and s two separate compeach floor. Dampe penetrations of sm heating, ventilating systems. 19.3.7 19.1.6.4  Based on observation facility failed to a through 1 of 7 sm protected to main of the smoke barrier sthe passamaterials such as protected so that penetrating item shall be filled with maintaining the s smoke barrier or approved device purpose. This deaffect any resident vicinity of the att near the Orchard  Findings include  Based on observation facility from the facility from	e constructed to provide at our fire resistance rating in a.3. Smoke barriers may fium wall. Windows are lated glazing or by wired steel frames. A minimum of partments are provided on are are not required in duct looke barriers in fully ducted and air conditioning 7.3, 19.3.7.5, 19.1.6.3, action and interview, the ensure 5 of 5 openings moke barriers were attain the smoke resistance arier. LSC Section 8.3.6.1 age of building service apipe, cable or wire to be the space between the and the smoke barrier that a material capable of smoke resistance of the be protected by an designed for the specific efficient practice could ant, staff or visitor in the fice smoke barrier wall. Drive office area.	K	0025	K 025:It is the policy of this facility to ensure openings through smoke barriers are protected to maintain the smoke resistance of the sm barrier. All residents have the potential to be affected by the finding. The smoke barrier we separating the Orchard Drive office area from the elevator corridor has been firestopped is in the closed position. As profit the preventative maintenance program, Maintenance Director will continue to monitor smoke barriers to ensure smoke resisitance. Any concerns to be immediately addressed accorrections will be made.	noke ne chis all d and art	11/07/2011

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	LTIPLE CON	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	of correction	155215	A. BUIL	DING	01	10/19/2	
		133213	B. WINC			10/19/20	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
PLAINFIE	ELD HEALTH CARE	CENTER			ARKS CREEK RD ELD, IN46168		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	CY MUST BE PERCEDED BY FULL	]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		smoke barrier wall					
		chard Dive office area					
	from the elevator						
		in diameter openings for					
	cables which are	each not firestopped.					
	b. one, three foot	by four foot access panel					
	which was in the	open position.					
	Based on intervie	ew at the time of					
	observation, the	Assistant Maintenance					
	Technician ackno	owledged four openings					
	in the smoke barrier wall above the						
	ceiling by the Orchard Drive office area						
	and the elevator	corridor which were not					
	firestopped and o	one access panel in the					
		all which was in the open					
	position.	1					
	r						
	3.1-19(b)						
	3.1 17(0)						
K0044		used, are in accordance					
SS=E	with 7.2.4. 19.2.						
		ation and interview, the	K0	044	K 044:It is the policy of this fa	-	11/07/2011
	facility failed to	ensure 3 of 3 access			to ensure access doors in the attic fire barrier walls maintain		
	doors in attic fire	barrier walls maintained			two hour fire barrier and are	ii u	
	a two hour fire ba	arrier and are equipped			equipped with a latching syst	em	
	with positive late	ching to provide the			to provide protection needed		
	protection needed	d for a two hour fire			two hour fire barrier. All reside have the potential to be affect		
	barrier. LSC 19.2	2.2.5 requires horizontal			by this finding. The maintenar		
	exits to be in acco	ordance with 7.2.4. LSC			director repaired the attic fire		
	7.2.4.3.4 requires	s any opening in fire			barrier near room 42, 47, and	136	
	barriers be protec	cted as provided in 8.2.3.			to ensure the fire barrier wal		
		_			maintained a two hour fire ba	irrier	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155215		A. BUI	LDING	NSTRUCTION  01	(X3) DATE COMPI 10/19/2	LETED	
		100210	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/10/2	.011
NAME OF I	PROVIDER OR SUPPLIER				ARKS CREEK RD		
PLAINFI	ELD HEALTH CARE	CENTER			IELD, IN46168		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	and are equipped with a la	tohina	DATE
		quires fire doors to be dance with NFPA 80. In			system to provide protection		
		0, Standard for Fire			needed for a two hour fire		
		ows at 2-1.4.1 requires all			barrier. The maintenance d		
		sms shall be adjusted to			will continue to monitor fire walls to ensure compliance		
	_	sistance of the latch			fire barrier regulations. Any		
	mechanism so po				concerns will be addressed		
		door operation. This			immediately and correction be made.	IS WIII	
		e could affect residents,			So mado.		
	*	in the vicinity of the attic					
		Room 42, Room 47 and					
	Room 136.						
	Findings include	:					
	Based on observa	ation with the Assistant					
		chnician during a tour of					
	1	1:00 p.m. to 3:45 p.m.					
		following was observed:					
		arrier wall near Room 42					
		f five eighths inch					
	1 -	access panel door in the					
		which measured three feet					
	1 -	isted of two layers of five					
	eighths inch dryv						
	equipped with a	positive latching					
	mechanism.	i					
		arrier wall near Room 27					
		f five eighths inch					
	1 -	access panel door in the					
		which measured three feet					
		isted of two layers of five					
	eighths inch dryv equipped with a						
	equipped with a	positive fatching					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155215			A. BUILE	DING	NSTRUCTION 01	(X3) DATE : COMPL 10/19/2	ETED
NAME OF P	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	10/19/20	011
PLAINFIE	ELD HEALTH CARE	CENTER			ARKS CREEK RD ELD, IN46168		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	drywall and the a fire barrier wall was by four feet conseighths inch drywequipped with a mechanism.  Based on interview observation, the archician acknowledge access door in the second control of t	ew at the time of Assistant Maintenance owledged each attic e fire barrier walls was nours and was not					
K0048 SS=E	patients and for the of an emergency. Based on record facility failed to fire extinguishers plan for the facility emergency. LSC written health carplan that shall profit (1) Use of alarms	review and interview, the include the use of kitchen in the written fire safety ity in the event of an C 19.7.2.2 requires a re occupancy fire safety ovide for the following:	K00	)48	K 048:It is the policy of this fato ensure the written Fire Emergency Procedure addrethe use of ABC type fire extinguishers and the K class extinguishers in the kitchen ir relationship with the use of the kitchen overhead extinguishin system. The facility Disaster Manuel has been revised to include the proper fire suppression measures in the	sses s fire n ne ng Plan	11/07/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BIIII	LDING	01	COMPI	
		155215	B. WIN			10/19/2	2011
NAME OF F	DOMED OF STREET	0		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	N.		3700 CL	ARKS CREEK RD		
PLAINFIE	ELD HEALTH CAR	E CENTER		PLAINF	IELD, IN46168		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	(3) Response to				kitchen.Dietary Staff has b inserviced on the use of Al		
	(4) Isolation of f				fire extinguishers and the I		
	` ′	of immediate area			fire extinguishers in the kit		
	1 1	of smoke compartment			relationship with the use o		
		of floors and building for			kitchen overhead extinguis		
	evacuation				system. Any staff who fail comply with the points in the		
	(8) Extinguishm	ent of fire			inservice will be further ed		
	This deficient pr	ractice affects any			and/or progressively	-	
	resident, staff an	nd visitors in the vicinity			disciplined.Maintenace		
	of the kitchen.				Department will continue to	)	
					monitor the facility fire suppression measures to	neuro	
	Findings include	2.			compliance.	risure	
	Based on a revie	ew of the facility's written					
	fire safety plan t	itled "Fire Emergency					
	Procedure" for	Plainfield Health Care					
	Center during re	cord review with the					
	1	enance Technician from					
		40 a.m. on 10/19/11, the					
		did not address the use of					
		xtinguishers and the K					
	l **	uisher located in the					
	_	onship with the use of the					
		d extinguishing system.					
		erview at the time of					
		he Assistant Maintenance					
		nowledged the written fire					
		he facility did not include					
		ning to activate the					
		extinguishing system to					
		efore using either the					
	l **	xtinguisher or the K class					
	fire extinguisher	· ·					
							<u> </u>
FORM CMS-2	567(02-99) Previous Versi	ions Obsolete Event ID:	HHL021	Facility II	D: 000121 If continuatio	n sheet Pa	ge 8 of 18

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155215 A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  10/19/2011				
	PROVIDER OR SUPPLIER			3700 CL	DDRESS, CITY, STATE, ZIP CODE LARKS CREEK RD IELD, IN46168		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0052 SS=C	installed, tested, a accordance with N Code and NFPA 7 approved mainten complying with approved mainten facility failed to a systems was mainten with the applicable facility failed to a systems was mainten with the applicable facility failed to a systems was mainten for the circuit facility failed to a systems was mainten for the circuit facility failed to a systems was mainten for the circuit facility failed to a system facility failed to a system facility failed to a system facility failed facility failed to a system facility failed facility failed facility facility failed facility	IFPA 70 National Electrical  2. The system has an ance and testing program plicable requirements of	K	0052	K 0052:It is the policy of this facility to ensure the Fire Ala breaker panel box is locked. maintenance director placed lock on the fire alarm breaker panel box. The maintenance director will cor to monitor the lock on the fire alarm breaker circuit as part the Preventative Maintenance Program. Any concerns will addressed immediately and corrections will be made.	The a ntinue e of e	11/07/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HHL021 Facility ID:

000121 If continuation sheet Page 9 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155215		A. BUIL	DING	O1		ETED
			3700 CL	ARKS CREEK RD		
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
conductors. This	deficient practice could					
Findings include	:					
Maintenance Tecthe facility from 10/19/11, the "Fi panel located nexemergency gener and breaker for the facility but the which it was local Based on interview observation, the Archnician acknows system breaker control of the facility but the which it was local based on interview observation, the Archnician acknows system breaker control of the facility of the faci	chnician during a tour of 1:00 p.m. to 3:45 p.m. on the Alarm 3" breaker at to the downstairs unit that or identified the circuit the fire alarm system for the breaker panel box in the ted was not locked. The entire that the time of the Assistant Maintenance to wledged the fire alarm ircuit in the Fire Alarm 3					
continuously main condition and are in periodically. 19. NFPA 25, 9.7.5 Based on observation facility failed to esprinkler heads in maintained. NFF Installation of Sp	tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, ation and interview, the ensure 3 of over 100 in the facility were PA 13, Standard for the prinkler Systems, Section	K0	0062	ensure the sprinkler heads in facility are maintained per NF 13, Standard for the Installatic Sprinkler Systems. The Maintenance Director repaire the missing escutheon plates	the PA on of d on	11/07/2011
	PROVIDER OR SUPPLIER  SUMMARY ST  (EACH DEFICIENCY REGULATORY OR  of connection to conductors. This affect all resident  Findings include  Based on observa Maintenance Tec the facility from 10/19/11, the "Fi panel located nex emergency gener and breaker for the the facility but the which it was located Based on intervier observation, the A Technician acknows system breaker control breaker panel was  3.1-19(b)  Required automatic continuously main condition and are in periodically. 19. NFPA 25, 9.7.5 Based on observa facility failed to of sprinkler heads in maintained. NFF Installation of Sp	DENTIFICATION NUMBER: 155215  PROVIDER OR SUPPLIER  ELD HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.  Findings include:  Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the "Fire Alarm 3" breaker panel located next to the downstairs unit emergency generator identified the circuit and breaker for the fire alarm system for the facility but the breaker panel box in which it was located was not locked.  Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged the fire alarm system breaker circuit in the Fire Alarm 3 breaker panel was not locked.  3.1-19(b)  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13,	PROVIDER OR SUPPLIER  ELD HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.  Findings include:  Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the "Fire Alarm 3" breaker panel located next to the downstairs unit emergency generator identified the circuit and breaker for the fire alarm system for the facility but the breaker panel box in which it was located was not locked.  Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged the fire alarm system breaker circuit in the Fire Alarm 3 breaker panel was not locked.  3.1-19(b)  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section	STREET AT 3700 CL PLAINFIL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC (DEINTIFYING INFORMATION)  of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.  Findings include:  Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the "Fire Alarm 3" breaker panel located next to the downstairs unit emergency generator identified the circuit and breaker for the fire alarm system for the facility but the breaker panel box in which it was located was not locked.  Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged the fire alarm system breaker circuit in the Fire Alarm 3 breaker panel was not locked.  3.1-19(b)  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section	OF CORRECTION  IDENTIFICATION NUMBER: 155215  ROUTDER OR SUPPLIER  ELD HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL). REGULATORY OR LSC IDENTEYING INFORMATION)  of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.  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NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3.2.7.2 states excutcheone plates used with	DENTIFICATION NUMBER: 155215    A BUILDING   1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		NSTRUCTION 01	(X3) DATE S COMPL		
		155215	A. BUI B. WIN	LDING IG	<del></del>	10/19/2	011
NAME OF E	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ARKS CREEK RD		
	ELD HEALTH CARE			PLAINF	IELD, IN46168		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	a recessed or flus	sh-type sprinkler shall be			Drive fire panel, near the Ord		
		orinkler assembly. This			Drive clean linen room, and r		
	deficient practice	e could affect any			the Orchard Drive kitchen.Th Maintenance Director will	е	
	resident, staff or	visitor in the vicinity of			continue to monitor the facilit	y	
	the Orchard Driv	re office area.			sprinkler system as part of th Preventative Maintenance	е	
	Findings include	:			program. Any concerns will be addressed immediately and corrections will be made.	e	
	Based on observa	ation with the Assistant					
	Maintenance Tec	chnician during a tour of					
	the facility from	1:00 p.m. to 3:45 p.m. on					
	10/19/11, the following	lowing areas each had					
	missing escutche	on plates which left a					
	two inch opening	g in the ceiling into the					
	attic from each a	rea:					
	a. Orchard Drive	fire panel room.					
	b. Orchard Drive	clean linen room.					
	c. Orchard Drive						
	Based on interview						
	,	Assistant Maintenance					
		owledged the Orchard					
	_	room, clean linen room					
		had missing escutcheon					
	-	a two inch opening in the					
	ceiling into the a	ttic from each area.					
	2 1 10(b)						
	3.1-19(b)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155215			LDING	NSTRUCTION  01	(X3) DATE ( COMPL 10/19/2	ETED	
	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE LARKS CREEK RD IELD, IN46168		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0067 SS=F	comply with the prare installed in accommunication and manufacturer's sponsored facility failed to a corridors were not return air system ventilating, or air ductwork serving 19.5.2.1 requires ventilating ductwequipment to be with NFPA 90A, Installation of Air Ventilating System 2-3.11.1 requires not be used as a preturn, or exhaus adjoining areas. could affect all register the modification of the modified the modified the HV ventilation, and the modified of the modified the HV ventilation, and the modified of the modified the HV ventilation, and the modified of the modified the HV ventilation, and the modified of the modified the HV ventilation, and the modified of the modified the HV ventilation, and the modified of the modified the HV ventilation, and the modified of the modified the HV ventilation, and the modified of the	ecifications. 19.5.2.1, 9.2, 2.2 ation and interview, the ensure 5 of 5 egress of used as a portion of a /plenum for heating, conditioning (HVAC) adjoining areas. LSC air conditioning, heating, work and related installed in accordance the Standard for the r Conditioning and ems. NFPA 90A, egress corridors shall portion of a supply, at air system serving This deficient practice esidents, staff and visitors ons had not been made.  Ention and interview with intenance Technician f the facility from 1:00 on 10/19/11, all resident g the egress corridor as a however, the facility has	K	0067	Corrective Action (K067): It the policy of to ensure the f dampers in the ductwork at smoke barriers are inspected and maintained at least ever four years. All residents have the potential to be affected this finding. The maintenan supervisor inspected all 80 dampers in the facility and are in working order. All repairs needed were compleat time of inspection. The facility has developed a tracking form for the inspection of the fire dampe which will be kept in the Facility Preventative Maintenance Log. The inspections and maintenance will be completed annually. Maintenance Director is responsible for maintaining these records. Please accepthis letter as an application a waiver for the K67 deficiency. This waiver request has been requested and approved on previous I Safety Code recertification. This waiver is supported by following facts: a. When the fire alarm system is triggered the supported is an automatic shut down on the air handlers. be	rire ed ry ve by ce fire all eted  ot for life r the eed,	11/07/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(A2) MC	JETIPLE CON	O1	(X3) DATE S COMPLI		
ANDILAN	of correction	155215	A. BUII	DING	01	10/19/20	
		130210	B. WIN			10/13/20	711
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ARKS CREEK RD		
PLAINFIE	ELD HEALTH CARE	CENTER			ELD, IN46168		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
	supply air fans hadownstream of the	ir fans. Additionally, the ave duct detectors located ne air filters that when			None of the existing cold ai returns go through a firewa Based upon the inspector's recommendation for a waive	II. er,	
	Finally, the HVA any fire or smoke need for the insta dampers interconsystem to prevent from one comparcompartments. Etime of observation Maintenance Technology (1997) and the HVA any fire of smoke the instance of the HVA any fire of smoke the instance of the HVA any fire of smoke the instance of the	the transfer of smoke the transfer of the transfer of smoke the tr			and the facts outlined above we request a waiver for K 6		
K0076 SS=E	are protected in action Standards for Heal Standards for Heal (a) Oxygen storage 3,000 cu.ft. are enceparation.  (b) Locations for set than 3,000 cu.ft. at NFPA 99 4.3.1.1.2 Based on observation facility failed to expect the oxygen standard for t	e locations of greater than closed by a one-hour upply systems of greater re vented to the outside.  2, 19.3.2.4 ation and interview, the ensure 2 of 2 electrical rgen storage and	KO	0076	K 0076:It is the policy of this facility to ensure electrical ou in the oxygen storage room a located at least five feet above	ire	11/07/2011
	_	were located at least five			the floor.The Maintenance Director capped the electrica		

SELECTIONS   NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS. CITY. STATE.ZIP CODE   3700 CLARKS CREEK RD   PLAINFIELD, IN46188	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  O1		(X3) DATE SURVEY COMPLETED		
STRIET ADDRESS, CITY, STATE, JIP CODE 3700 CLARKS CREEK RD PLAINFIELD HEALTH CARE CENTER  (A4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG RECULTATOY OR ISC IDENTIFYING INFORMATION)  feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.1.2(a) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a) requires electrical fixtures ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect any residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.  Findings include:  Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3-45 p.m. on 10/19/11, there are two electrical outlets on the wall in the oxygen storage and transfilling room. Each electrical outlet was one foot and six inches in height from the floor of the oxygen storage and transfilling room. Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged two electrical outlets are on the wall of the oxygen storage and					<del></del>		
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than five feet above the floor.	than five feet abo	ove the floor.					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155215		X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING  (X3) DATE SUIT COMPLET: 10/19/201			ETED		
		100210	B. WIN			10/19/2	O 1 1
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PLAINFIE	ELD HEALTH CARE	CENTER			LARKS CREEK RD TIELD, IN46168		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144 SS=C	exercised under lo	spected weekly and had for 30 minutes per lince with NFPA 99.					
	3.4.4.1.  1. Based on record the facility failed documentation for emergency generative emergency light 7.9.2.3 and NFP 7.9.2.	ord review and interview, to provide complete or testing 2 of 2 rators providing power to ghting systems. LSC A 99, Health Care 1.8 requires the generator sufficient capacity to pick neet the minimum oltage stability the emergency system is after loss of normal cient practice could its, staff and visitors.	KO	)144	It is the policy of this facility to provide complete documentation testing the emergency generators providing power to emergency lighting systems. Generator Load Test documentation is completed the Maintenance Director earnorth. This documentation provides generator run tests least thirty minutes each more percentage of load capacity of minimum gas exhaust temperature, and the logs resulted the main source to each emergency generator. The Generator Load Test documentation is part of the facility Preventative Maintenator Program. Any concerns will be addressed immediately and corrections will be made.	o the The by ch for at nth, or cord m	11/07/2011
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID: H	HL021	Facility I	ID: 000121 If continuation sl	neet Pag	ge 15 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155215		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATE SURVEY  COMPLETED  10/19/2011			ETED		
NAME OF	PROVIDER OR SUPPLIER	<b>1</b>	-	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
					LARKS CREEK RD		
	ELD HEALTH CARI			<u> </u>	IELD, IN46168		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		riod of 10/18/10 through					
	1	logs utilized by the					
		ecord the time to transfer					
	I -	main source to each					
	emergency gene	rator. Based on interview					
	at the time of rec	cord review, the Assistant					
	Maintenance Tec	chnician acknowledged					
	the transfer time	to transfer power to each					
	emergency gene	rator was not recorded for					
	each month.						
	3.1-19(b)						
	2. Based on reco	ord review and interview,					
	1	d to ensure a monthly load					
		nergency generators was					
		of 12 months using one of					
		ng methods: under					
		rature conditions, at not					
		the Emergency Power					
		meplate rating, or loading					
		e minimum exhaust gas					
		recommended by the					
	manufacturer. Chapter 3-4.4.1.1 of NFPA						
	•	thly testing of generators					
	serving the emergency electrical system to be in accordance with NFPA 110.						
		NFPA 110.					
	_	Level 1 and Level 2					
		ercised at least once					
	monthly, for a minimum of 30 minutes, using one of the following methods:						
	1 -	ng temperature conditions					
	_	n 30 percent of the EPS					
		1					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION N		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	A. BUI	LDING	NSTRUCTION 01	(X3) DATE COMPL 10/19/2	ETED
		100210	B. WIN		DDDEGG CITY OT TO CORE	10/18/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE LARKS CREEK RD		
PLAINFI	ELD HEALTH CARI	E CENTER			IELD, IN46168		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETION DATE
TAG	nameplate rating	*		TAG	DEFICIENCY)		DATE
	1 1	naintains the minimum					
	exhaust gas temp						
		y the manufacturer.					
	_	ne of day for required					
		lecided by the owner,					
	_	operations. This					
	deficient practice	•					
	residents, staff a						
		1101010					
	Findings include	:					
	Based on review	of "Generator Load					
	Test-Downstairs	Unit" and "Generator					
	Load Test-Shed	Unit" documentation with					
	the Assistant Ma	intenance Technician					
	during record re-	view from 9:45 a.m. to					
	11:40 a.m. on 10	0/19/11, the Downstairs					
	Unit and the She	d Unit emergency					
	generators were	each run on a monthly					
	basis for at least	thirty minutes each					
	_	riod of 10/18/10 through					
	09/19/11 but the logs utilized by the						
	1	ecord the minimum					
	exhaust gas temperature or the percentage of load capacity for the monthly load test						
	conducted on 06						
	emergency generator. Based on interview						
		cord review, the Assistant					
		chnician acknowledged					
	_	ntage of load capacity or					
		st gas temperature was					
		06/13/11 monthly load					
	test for each eme	ergency generator.					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215		LDING	OSTRUCTION  01	(X3) DATE COMPI 10/19/2	ETED
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE _ARKS CREEK RD		
PLAINFIELD HEALTH CARE CENTER					TELD, IN46168		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	3.1-19(b)						